STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING ______ B. WING ______	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	**3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, record review and staff interviews, the facility failed to provide an individualized activity program for 1 of 3 residents sampled for activities. (Resident #128). The findings included: Resident #128 was admitted to the facility 01/16/15 with diagnoses of hypertension, Alzheimer's Disease, difficulty walking, and was placed immediately under isolation for the infection of clostridium difficile (c-diff). The admission Minimum Data Set (MDS), dated 01/23/15, coded Resident #128 as scoring 00 out of 15 on the Brief Interview for Mental Status indicating he had severely impaired cognition. He was also coded as requiring extensive assistance for bed mobility, transfers, toileting and being nonambulatory. The MDS noted the resident participated in the specific questions related to activity preferences. Per this MDS, Resident #128 noted newspapers, music, animals, new activities, being outside and religion were not very important to him. He offered no response to the question related to the importance of group activities and doing his favorite activities were	F 248	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F248 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Resident # 128 no longer resides at the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The Administrator or designee will audit	4/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/21/2015

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somewhat important. The section for previous occupation was blank on the MDS.

Review of the computerized medical record revealed the activity assessment was due on 01/23/15 and had not been completed as of 03/24/15. There were no notes or any indication as to his past employment, interests, abilities and there was no care plan developed to engage him in activities.

Resident #128 was observed in his room in bed on 03/23/15 at 1:12 PM, and 1:27 PM, at 1:43 PM, at 2:51 PM and at 4:12 PM. The only time he was observed engaged in any activity was at 4:12 PM when he had 2 visitors at his bedside.

He was observed on 03/24/15 at 10:03 AM sitting opposite the nursing station in his wheelchair and in the hall at 11:55 AM. Neither time was he interacting with anyone. He was in bed on 03/24/15 at 3:37 PM not engaged in any activity.

On 03/25/15 he was in his room dozing at 9:44 AM and at 9:54 AM. At 10:37 AM on 03/25/15 he was noted to be in the shower room taking a shower. On 03/25/15 at 11:07 AM he was in his room asking to go back to bed. Staff proceeded to put him to bed per requested and he remained in bed asleep at 11:57 and at 2:37 PM.

On 03/26/15 at 6:11 AM two nurse aides #2 and #3 proceeded to provide him care. While providing care, they told the surveyor who was observing care that Resident #128 was a meteorologist. Resident #128 remained in bed dozing but not watching television on 03/26/15 at 9:51 AM, at 10:06 AM, 10:21 AM, 11:12 AM, and at 12:55 PM.

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current residents, including residents on isolation, for appropriate completion of activity assessments. Results of the audit were assessed, reviewed, and careplanned, and activities implemented per resident preferences. Confused and isolated residents will be audited for timely completion and accuracy of activity assessment for One on One individual activity programs.

Measures to be put in place or systemic changes made to ensure practice will not Re-occur-

During daily (Mon-Fri) standup meetings, the activity director or designee will review all new activity assessments.

Based on assessments, individual activities will be provided through a One on One program. Residents that have been identified as confused and residents that are on isolation, will be provided activities through a One on One program, such as television, radios, books, puzzles and puzzle books.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-

Weekly audits will be performed every week for one month and monthly for two months by MDS for activity director, to ensure timely, accurate completion of activity assessments. Results of the audit will be assessed, reviewed, and

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F 248	Continued From page 2 Interview with the Activity Director (AD) on 03/26/15 at 1:04 PM revealed she had not completed the assessment. She related that she had just started within the last month and was not in the facility when Resident #128 was admitted. She further stated she could not locate any records for Resident #128 related to any assessment, documentation of preferences, or activity participation. She stated that she could not provide activities to him when he was on isolation and as an alternative she offered on 2 occasions to bring him magazines or word search. She subsequently confirmed his cognition would not permit him to be able to complete word searches. Because he was in isolation, she stated she could only talk to him. She further stated that she did not normally provide activities for residents on isolation. She could not provide documentation of her visits with the resident or his participation during her visits. She further stated that her plan was to provide one on one visits including music to Resident #128 as she believed residents with dementia responded well to music, however, she confirmed she did not know if Resident #128 liked music and if so the type of music. She also stated she generally would start introducing music that was popular for his age group. She had not contacted family to determine past preferences. Interview with the Administrator on 03/26/15 at 1:46 PM revealed when a resident was on isolation for c-diff, the resident was not permitted to leave the room for anything. She stated he had been on isolation since admission and recently taken off of isolation, just before the survey. She further stated that from the end of November 2014 to late February 2015 the activity	F 248	careplanned, and activities implemented per resident preferences. Confused and isolated residents will be audited for timely completion and accuracy of activity assessment for One on One individual activity programs, with responses to activities documented during quarterly review in the medical record. Monitoring of results will be reported to Quality Assurance Weekly Risk Management Meeting X three months and Quarterly Quality Assurance Meetings X 1 for further problem resolution.	

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director position was vacant and she enlisted the assistance of a nurse aide with a background in activities to assist with activities. She stated that because of him being in isolation the staff were limited in the activities they could offer short of asking family to come and sit with him.

On 03/27/15 at 9:58 AM, Resident #128 was sitting opposite the nursing station in the hall in his wheelchair. During conversation, he stated he had been in the Korean war as part of the navy. After the navy he was employed at the National Weather Center. After the surveyor and the resident chatted, he thanked the surveyor for talking with him and stated it was "its good to have someone to talk to on a day like this."

The nurse aide (NA) #1 who assisted with activities while there was no activity staff was interviewed on 03/27/15 at 11:53 AM. NA #1 revealed that she worked in the activity department from December 2014 until a month ago. She revealed she was responsible for obtaining oral histories from the residents, gave them to the MDS staff to input into the MDS system. She further revealed when she interviewed Resident #128 he was very confused and she could not obtain information regarding preferences from him. She further stated that being an interim activity staff, she did not contact family to obtain additional information related to interests as she did not thinks that was her responsibility. She did say that Resident #128 had been in the military but that was about what she was able to ascertain from him. She stated that she offered him a model airplane to tinker with but he did not seem interested. As a result she visited him and would just try to engage him in conversation about anything he would talk

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F 248	Continued From page 4 about but he often did not engage in conversation. She further stated she did not document any interaction with Resident #128. On 03/30/15 at 9:45 AM MDS staff #2 was interviewed via phone and revealed that she worked part time and interviewed Resident #128 for the MDS questions related to activity preferences. She stated that she filled out the information on the MDS form related to her findings from the interview but did not proceed any further in relation to an activity care area assessment, care plan or passing the information she gathered to the activity director/staff for development of an activity plan.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		4/24/15

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F 272	Continued From page 5 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		
	This REQUIREMENT is not met as evidenced by: Based on resident interview, record review and staff interviews, the facility failed to assess activity preferences and abilities for 1 of 3 residents sampled for activities. (Resident #128). The findings included: Resident #128 was admitted to the facility on 01/16/15 with diagnoses of hypertension, Alzheimer's Disease, difficulty walking, and was placed immediately under isolation for the infection of clostridium difficile (c-diff). The admission Minimum Data Set (MDS), dated 01/23/15, coded Resident #128 as scoring 00 out of a possible 15 on the Brief Interview for Mental Status indicating he had severely impaired cognition. He was coded as requiring extensive assistance for bed mobility, transfers, toileting		F272 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident # 128 no longer resides at the facility How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Activity Director/designee will interview all current residents for appropriate activity assessments. If the residents are unable to answer questions, the family will be called to answer questions of resident s	

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F 272 Continued From page 6

and being nonambulatory. The MDS noted the resident participated in the specific questions related to activity preferences. Per this MDS, Resident #128 noted newspapers, music, animals, new activities, being outside and religion were not very important to him. He offered no response to the question related to the importance of group activities and doing his favorite activities were somewhat important. The section for previous occupation was blank on the MDS.

Review of the computerized medical record revealed the initial activity assessment was due on 01/23/15 and had not been completed as of 03/24/15. There was no Care area Assessment (CAA) completed for the area of activities for Resident #128 which identified his strengths, weaknesses, abilities, and whether a care plan would be developed and why.

Interview with the Activity Director (AD) on 03/26/15 at 1:04 PM revealed she had not completed the CAA or other computerized assessment relative to activities the facility utilized. She related that she had just started within the last month and was not in the facility when Resident #128 was admitted. She further stated she could locate no records for Resident #128 related to any assessment or activity participation. She stated that on occasion she would contact family members for information related to preferences.

Interview with the Administrator on 03/26/15 at 1:46 PM revealed when a resident was on isolation for c-diff, the resident was not permitted to leave the room for anything. She stated he had been on isolation since admission and was

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past/current activity interests. The Activity Director was in-serviced on 04/23/2015 by the Administrator regarding what constitutes an appropriate activity assessment using facility Policy #202 which states patient□s activity interests and preferences, spiritual support, scope of activities participation, limitations or special needs of the resident.

Measures to be put in place or systemic changes made to ensure practice will not Re-occur-

Weekly x 3 months, during daily standup meetings (Mon-Fri) the activity director or designee will review new residents□ activity assessments for accuracy and timeliness.
An audit will be performed by MDS on 8 completed activity assessments every week for one month and monthly for two months to ensure timely, accurate completion of activity assessments.
How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-

Results of audit will be reported to the Quality Assurance Risk Management Committee weekly x three months and Quarterly x 1 to the Quality Assessment & Assurance Committee to ensure continued compliance or revisions to the plan.

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F 272	Continued From page 7	F 272		

recently taken off of isolation, just before the survey began. She further stated that from the end of November 2014 to late February 2015 the activity director position was vacant and she enlisted the assistance of a nurse aide with a background in activities to assist with activities.

The nurse aide (NA) #1, who assisted with activities while there was no activity staff, was interviewed on 03/27/15 at 11:53 AM. NA #1 revealed that she worked in the activity department from December 2014 until a month ago. She revealed she was responsible for obtaining oral histories from the residents, gave them to the MDS staff to input into the MDS system and provided activities. She further revealed when she interviewed Resident #128 he was very confused and she could not obtain information regarding preferences from him. She further stated that being an interim activity staff, she did not contact family to obtain additional information related to interests as she did not thinks that was her responsibility. She did say that Resident #128 had been in the military but that was about what she was able to ascertain from him. As a result she visited him and would just try to engage him in conversation about anything he would talk about but he often did not engage in conversation.

On 03/27/15 at 9:58 AM, Resident #128 was sitting opposite the nursing station in the hall in his wheelchair. while talking with him, Resident #128 stated he had been in the Korean war as part of the navy. After the navy he was employed at the National Weather Center.

On 03/30/15 at 9:45 AM MDS staff #2 was interviewed via phone and revealed that she

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F 272	Continued From page 8 worked part time and interviewed Resident #128 for the MDS questions related to activity preferences. She stated that she filled out the information on the MDS form related to her findings from he interview but did not proceed any farther in relation to an activity care area assessment.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		4/24/15

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F 278	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility did not accurately report resident information on a Minimum Data Set (MDS) assessment for 1 of 1 residents (Resident #126). Findings included: Resident #126 was admitted to the facility on 10/07/14 with diagnoses including altered mental status and delirium. MDS assessment dated 10/14/14 indicated Resident #126's cognitive ability was moderately impaired. MDS assessments dated 10/14/14 reported that Resident #126 did not demonstrate behaviors. A staff interview was conducted with Nurse #2 on 03/27/15 at 3:13 PM. Nurse #2 reported that Resident #126 was verbally abusive and rude to female staff adding that he observed Resident #126 engaged in abusive, rude behavior on the first day he provided care for him soon after his admission and continuing throughout his stay until Resident #126 was discharged. A staff interview was conducted with NAs #7 and #4 on 03/27/15 at 3:27 PM. NAs #7 and #4 indicated that Resident #126 frequently made unwelcomed comments concerning their appearance and his desires toward them. They reported that Resident #126 would grab at their buttocks or toward their lower abdomens. NA #7 and NA #4 verbalized that the experienced Resident #126's described behaviors beginning at the time of his admission and continuing throughout his stay until Resident #126 was	F 278	F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #126 is no longer a resident at the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice MDS was inserviced 4/21/15 on reviewing the Point Click Care- Point of Care report for C.N.A documentation on behaviors, and the Point Click Care Progress note report for behavior notes written by nursing staff. The MDS Coordinator or designee will audit current residents as of 04/21/2015 for behaviors, found by running Point Click Care Report looking for CNA and Nursing documentation for documented behaviors. MDS will review behaviors during the ARD period for current residents to ensure that behaviors are being captured. This information will ensure coding is captured based on documented behaviors by nursing staff. Measures to be put in place or systemic changes made to ensure practice will not Re-occur:	

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F 278	Continued From page 10 discharged. A staff interview was conducted and MDS nurse notes were reviewed with MDS Nurse #1 on 03/30/15 at 11:48 AM. MDS Nurse #1's notes recorded that Resident #126's behaviors were first reported on 10/10/14. MDS Nurse #1 verbalized that Resident #126's behaviors should have been recorded on the MDS assessment dated 10/14/14 since they were reported to her on 10/10/14.	F 278	During daily (Mon-Fri) Stand-up meetings the MDS Coordinator or designee will review all new MDS s for appropriate coding by reviewing the Point Click Care-Point of Care report for C.N.A documentation on behaviors, and the Point Click Care Progress note report for behaviors written by nursing staff. The MDS Coordinator will audit documentation of behaviors daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The MDS Coordinator will report the results of these audits in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		4/24/15

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F 279	Continued From page 11 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility did not care plan for resident behaviors toward others for 1 of 1 residents (Resident #126). Findings included: Resident #126 was admitted to the facility on 10/07/14 with diagnoses including altered mental status and delirium. Minimum Data Set (MDS) dated 10/14/14 assessment indicated Resident #126's cognition was moderately impaired. MDS assessments dated 10/14/14 reported that Resident #126 did not demonstrate behaviors. A review of Resident's care plan current at the time of his discharge from the facility on 03/21/15 revealed that Resident #126's behaviors had not been included in his care plan. A staff interview was conducted with Nurse #2 on 03/27/15 at 3:13 PM. Nurse #2 reported that Resident #126 was verbally abusive and rude to female staff adding that he observed Resident #126 engaged in abusive, rude behavior on the	F 279	F279 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #126 no longer a resident at the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The MDS Coordinator performed 100% audit on current residents as of 4/21/2015. Behaviors and care-plans were be updated to include behavior care plan. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- All new admissions and readmissions will be reviewed for behaviors. The Director of Nursing/Unit Manager or designee and MDS Coordinator will review the Point Click Care- Point of Care report for C.N.A documentation on behaviors, and the	

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F 279	Continued From page 12 first day he provided care for him soon after his admission and continuing throughout his stay until Resident #126 was discharged. A staff interview was conducted with NAs #7 and #4 on 03/27/15 at 3:27 PM. NAs #7 and #4 indicated that Resident #126 frequently made unwelcomed comments concerning their appearance and his desires toward them. They reported that Resident #126 would grab at their buttocks or toward their lower abdomens. NA #7 and NA #4 verbalized that they experienced Resident #126's described behaviors beginning at the time of his admission and continuing throughout his stay until Resident #126 was discharged. A staff interview was conducted with MDS nurses #2 on 03/30/15 at 10:07 AM. MDS Nurse #2 verbalized that he would expect Resident #126's behaviors to be care planned with focuses and interventions related to the behaviors. A staff interview with Social Worker (SW) was conducted on 3/30/15 at 10:15 AM. The SW verbalized that Resident #126's behaviors should have been care planned along with specific interventions related to them. The SW was unable to produce any documentation related to care plan meetings concerning Resident #126's behaviors. A staff interview with MDS Nurse #1 was conducted on 03/30/15 at 11:48 AM. MDS Nurse #1 verbalized that Resident #126's behaviors were first reported to her on 10/10/14 and should have been discussed in a care plan meeting then care planned with focuses and interventions related to the behaviors. MDS Nurse #1	F 279	Point Click Care Progress note report for behavior notes written by nursing staff. This will ensure that MDS and Nursing are identifying the same residents with behaviors and care planning appropriately. The MDS Coordinator will audit daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The MDS Coordinator or designee will report results of these audits in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	

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F 279	Continued From page 13 confirmed that there was no note related to a care plan meeting concerning Resident #126's behaviors and that his behaviors were not care planned.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to update the fall care plan interventions for 2 of 3 sampled residents reviewed for falls (Resident #128 and #76). The findings included:	F 280	F280 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident # 128 no longer resides at the facility. Resident #76 fall interventions have been care planned appropriately.	4/24/15

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F 280	Continued From page 14 1. Resident #128 was admitted to the facility on 01/16/15 with diagnoses of hypertension, Alzheimer's Disease, and difficulty walking. The admission Minimum Data Set (MDS) dated 01/23/15 coded Resident #128 as severly cognitively impaired. He was coded as needing extensive assistance with bed mobility, transfers, toileting and was nonambulatory. He was coded has having had a fall in the previous 6 months but none since this admission. The Care Area Assessment for falls dated 01/28/15 revealed he was confused and his primary mode of transportation was a wheelchair. It was noted that he had a history of multiple falls at his previous facility. Resident #28 was currently receiving therapy. The care plan established 01/28/15 addressed Resident #128's risk for falls related to confusion, balance and gait problems and history of falls. This care plan had the goal for the resident to have no significant injury from falling and included interventions of ensuring the environment was free of trip hazards, the call light was in reach, he participated in activities that promote physical activity and strengthening, he used a walker and one person assist, he wore appropriate foot wear, and used wheelchair for locomotion. The nursing notes reflected falls on 02/10/15 at 6:10 AM, 02/19/15 at 10:58 AM, and again at 6:52 PM; on 03/04/15 at 2:48 PM; on 03/10/15 at 5:22 PM; and on 03/13/15 at 10:37 AM. The notes indicated that Resident #128 had alarms in place in his wheelchair and in bed since at least 02/10/15. The fall that occurred on 03/13/15 indicated fall mats were in place. Nursing notes	F 280	How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Director of Nursing/Unit Manager or designee will audit current residents with falls as of 4/20/2015 to determine that fall interventions are careplanned appropriately. The Director of Nursing re-educated the Unit Manager on her role when a fall occurs including care plan revisions, patient monitoring, appropriate referrals, and communication to staff for all recommendations. This inservice was conducted on 4/22/2015. Measures to be put in place or systemic changes made to ensure practice will not Re-occur: The Unit Manager verifies correct fall interventions are included on each care plan. The Unit Manager is responsible for implementing patient monitoring, appropriate referrals, and communication to staff for all recommendations. The Director of Nursing/Unit Manager or designee will review the 24 Hour Report and Point Click Care documentation for falls to ensure that the appropriate interventions are placed on the care-plan	

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F 280	Continued From page 15 on 03/16/15 indicated that family was informed and gave permission to have an alarmed self release seat belt placed in the wheelchair. The care plan was updated to reflect falls which occurred on 03/04/15, 03/10/15, 03/13/015 and 03/15/15. However, there were no new interventions added and the care plan did not include the specific interventions of fall mats, or alarms or the self release seat belt. Interview on 03/23/15 at 1:34 PM with Nurse #4 revealed Resident #128 had multiple falls from his wheelchair and bed and now used a self release seat belt on his wheelchair. Resident #128 was observed to have a low bed, mats on the floor on each side of his bed and a pressure bed alarm in use during observations made on 03/24/15 at 3:37 PM; on 03/25/15 at 11:57 AM, 2:37 PM; on 03/26/15 at 5:45 AM. Resident #128 was observed in a high back reclining wheelchair, with anti-tip bars on the front and back, and a self release alarm belt in place when he was observed in his wheelchair on 03/25/15 at 9:23 AM, 9:54 AM, at 11:07 AM and 3:40 PM. On 03/26/15 at 6:15 AM, Nurse Aide (NA) #2 stated that NAs get their information related to specific care resident needs by word of mouth from the nurse or the nurse aide leaving the prior shift. She also stated there was a care guide available for review at the nursing station. At this time the care guides for this resident's hall was reviewed and there was no information located in the book for Resident #128. A different resident name was written in Resident #128's room	F 280	and revise the careplan as necessary. If the appropriate interventions are not careplanned it will be addressed at the time of the audit. The audits will review actual fall careplans daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	

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F 280	Continued From page 16 numbered slot. On 03/26/15 at 6:23 AM the unit manager stated there were instructions for nurse aides also located in the point click care computer system that nurse aides could utilize. Review of the point click care information for nurse aides to follow revealed that the interventions of a low bed, floor mats on each side of the bed, a bed alarm and a self release alarmed seat belt were not listed as needing to be used for Resident #128. Interview with the Administrator and the Director of Nursing on 03/26/15 at 1:56 PM revealed that nurse aides can pull the care guide from the notebook or they can print a list of care guide information off the computer. At the time of the fall a nurse is to initiate an intervention if appropriate and place the intervention on the care plan. The point click care computer system was set up to link the interventions with the incident reports and the nurse aide care guides. Then all falls and interventions are reviewed at the weekly falls meeting. During a follow up interview on 03/26/15 at 2:16 PM, the Administrator confirmed that the care plan did not reflect all the interventions Resident #128 should have in place including the low bed, fall floor mats, bed alarm and alarmed self release seat belt. She further stated that all interventions implemented should be listed for staff to access the information. 2. Resident #76 was readmitted on 01/11/14 with diagnoses including hemiplegia, contractures of the lower left leg joint, hypotension, and muscle weakness.	F 280		

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F 280	Continued From page 17 Review of a care plan dated 04/24/14 revealed Resident #76 had a high risk for falls related to confusion, gait and balance problems, and hemiparesis. Interventions included to anticipate and meet his needs, keep call light in reach and encourage to call for assist, left arm tray for support of extremity in wheelchair, assist bars to aide in bed mobility, and geo mattress with wings to assist with identifying parameters of bed. Review of an annual Minimum Data Set (MDS) dated 05/15/14 revealed Resident #76 had severely impaired cognition and required extensive assistance with bed mobility and transfers. The annual MDS noted Resident #76 had impaired range of motion of his upper and lower extremity on one side of his body and walking did not occur. In addition, no falls were noted since the previous assessment. Review of a Care Area Assessment (CAA) Summary for falls dated 05/15/14 revealed Resident #76 was at risk for falls due to confusion, gait and balance problems, and hemiparesis. The CAA Summary noted the attempts would be made to keep staff and routine consistent and he would be care planned for optimal safety. Review of a care plan dated 10/27/14 revealed Resident #76 had an actual fall with no injury related to hypotension. Interventions included to continue the interventions on the at risk care plan, monitor for adverse effects of medications, educate to call for assistance, and pharmacy consult. Review of Resident #76's post fall assessments	F 280		

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and fall documentation revealed the following:
- On 10/11/14 at 1:52 AM Resident #76 was found lying on the floor next to his bed. Bed bolsters were added to define the parameter of the bed.
- On 10/12/14 at 8:10 AM Resident #76 was found lying on the floor next to his bed. He told the nurse he lost control rolling over in bed. The bed bolsters were continued as an intervention.
- On 10/26/14 at 8:30 AM Resident #76 was found on the floor next to his bed. He told the nurse he was trying to get up to go to the kitchen. Personal alarms were added for safety.
- On 11/10/14 at 4:44 AM Resident #76 was found on the floor next to his bed. The bed bolsters and bed alarm were in place. Falls mats were implemented on both sides of his bed.

Resident #76 was observed on 03/23/15 at 11:00 AM up and dressed in his wheelchair wearing a splint on his left leg and foot. A seat pad alarm and foot rests were also noted. Subsequent observations of Resident #76 in bed on 03/24/15 at 3:40 PM, 03/25/15 at 10:37 AM and 03/26/15 at 8:00 AM revealed a low bed with bilateral bolsters, mats on the floor on each side of his bed and a pressure bed alarm in use.

An interview with Nurse Aide (NA) #4 at 03/26/15 at 1:07 PM revealed Resident #76 had a history of falls and had personal alarms used in his chair and bed. NA #4 stated his bed was kept in the low position with bilateral bolsters and mats on the floor on each side of his bed.

An interview was conducted with the Administrator on 03/26/15 at 1:50 PM. During the interview the Administrator stated the nurse present at the time of the fall would be expected

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F 280	Continued From page 19 to update the resident's care plan to include any new interventions that were implemented. The Administrator explained the facility's at risk meeting may not occur until a few days after a fall and they did not routinely review the resident's care plan during the meeting. The Administrator stated Resident #76's care plan should have been updated to include the bed bolsters, bed and chair alarms, low bed, and fall mats.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to administer an as needed antianxiety medication for 1 of 3 sampled residents who requested as needed medications (Resident #114). The findings included: Resident #114 was admitted on 02/12/15 for rehabilitation services after a hospitalization with diagnoses including depression. Review of an admission Minimum Data Set (MDS) dated 02/19/15 revealed Resident #114 was cognitively intact.	F 309	F309 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #114 no longer resides at the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The DON (Director of Nursing)/Unit	4/24/15

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F 309	Continued From page 20 Review of physician's orders for March 2015 revealed Resident #114 was ordered Ativan (antianxiety medication) 0.5 mg (milligrams) by mouth every six hours as needed for anxiety. During an interview on 03/26/15 at 9:07 AM Resident #114 stated he had waited two hours for a dose of his as needed Ativan recently but could not recall the exact day. Resident #114 further stated he knew he waited two hours because he had looked at the clock. Resident #114 explained he sometimes felt nervous and his hands would shake and the Ativan helped with these symptoms. Resident #114 stated he was told the nurses were in report as the reason for the delay. An interview was conducted with the Administrator on 03/30/15 at 10:22 AM. During the interview the Administrator stated residents should not have to wait two hours for the nurse to administer medications after they were requested. The interview further revealed the Administrator was not aware of any problems or concerns regarding medication pass.	F 309	Manager or designee interviewed current alert & oriented residents to ensure as needed medications were given timely. No other residents verbalized concerns regarding not receiving as needed medications timely. Other residents medication administration records were reviewed to ensure they received as needed medications in a timely manner. The DON/Unit Manager or designee re-educate current licensed nurses, completed by 4/24/2015 as to timelines and effectiveness of as needed medications. Any licensed nurse that did not complete this education will be removed from the schedule until education is completed. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- The Director of Nursing/Unit Manager or designee will interview 10% of current census of those residents taking as needed medications for timeliness of medication administration. These interviews will be conducted - daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. The Director of Nursing/Unit Manager or designee will inservice all newly hired nurses in orientation that as needed	

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F 309	Continued From page 21	F 309	medications must be given in a timely manner. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide scheduled showers for 3 of 7 residents reviewed for activities of daily living (Residents #104, #114, and #129) The findings included: 1. Resident #104 was admitted on 03/01/15 for rehabilitation services after a hospitalization with diagnoses including muscle weakness. Review of an admission Minimum Data Set (MDS) dated 03/08/15 revealed Resident #104	F 312	F312 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident # 104, #114 no longer reside at the facility and #129 has been interviewed and documentation reflects that the resident has received showers as scheduled. How corrective action will be accomplished for those residents having	4/24/15

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was cognitively intact and required extensive assistance with transfers and one person physical assistance with bathing.

Review of the facility's shower book revealed Resident #104's showers were scheduled for every Tuesday and Friday during the 3:00 PM to 11:00 PM shift. Review of available shower documentation for Resident #104 revealed showers were initialed as completed on 03/10/15 and the therapy department staff assisted her with a shower on 03/17/15 (Tuesday).

During an interview on 03/25/15 at 9:10 AM Resident #104 stated her last shower had been on Monday or Tuesday of the previous week and she would like a shower more frequently.

An interview was conducted with Nurse Aide (NA) #12 on 03/27/15 at 3:17 PM. NA #12 confirmed she worked on Resident #104's hall on 03/20/14 (Friday) during the 3:00 PM to 11:00 PM shift. NA #12 did not recall if any showers were given that evening or if Resident #104 received her scheduled shower on 03/20/15 because she typically stayed on the hall and her coworker completed the showers. The interview further revealed if there were not enough NAs scheduled then scheduled showers were not given.

An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift.

During an interview on 03/30/15 at 12:05 PM NA #13 confirmed she worked on Resident #104's

F 312

the potential to be affected by the same deficient practice
Current alert and oriented residents or family members were interviewed regarding receiving showers. The Director of Nursing/Unit Manager or designee re-educate current certified nursing assistants and licensed nurses to be completed by 4/24/2015, that showers must be completed as scheduled and documented. If resident refuses or is out of the facility the certified nursing assistance must report to the nurse and document. The nurse will discuss with the resident and document in the medical record. Any CNA/nurse that does not complete education will be removed from the schedule until education is completed.

Measures to be put in place or systemic changes made to ensure practice will not Re-occur -

The Director of Nursing/Unit Manager or designee will audit shower logs to validate that patients received showers as scheduled (unless contraindicated, refused, or out of facility - daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1.

The Director of Nursing/Unit Manager or designee will educate all newly hired certified nursing assistants in orientation that showers must be completed as scheduled and documented. If resident refuses or is out of the facility the certified

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CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23 hall on 03/20/14 (Friday) during the 3:00 PM to 11:00 PM shift. NA #13 did not recall assisting Resident #104 with a shower that evening. NA #13 stated there were only 6 NAs for the facility that evening and they would not have been able to complete all the scheduled showers but would have offered residents a bed bath. 2. Resident #114 was admitted on 02/12/15 for rehabilitation services after a hospitalization with diagnoses including chronic obstructive pulmonary disease and coronary artery disease. Review of an admission Minimum Data Set (MDS) dated 02/19/15 revealed Resident #114 was cognitively intact and required one person assistance with bathing. Review of the facility's shower book revealed Resident #114's showers were scheduled for every Wednesday and Saturday during the 3:00 PM to 11:00 PM shift. Review of available shower documentation for Resident #114 revealed showers were initialed as completed on 03/04/15, 03/07/15, and 03/18/15. During an interview on 03/23/15 at 1:20 PM Resident #114 stated he did not choose how many showers he had a week and was last showered on Wednesday (03/18/15). Resident #114 further stated he did not receive his scheduled shower on Saturday (03/21/15) and was told there were not enough staff working to give showers. Observations of Resident #114 on 03/23/15 at 1:20 PM revealed his hair was unclean with white flaky particles noted at his hairline and several days growth of facial hair. On 03/24/15 at 11:54	F 312	nursing assistance must document this. . How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The Director of Nursing/Unit Manager or designee will audit to validate that patients received showers as scheduled (unless contraindicated, refused, or out of facility - daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X 1for further problem resolution.	

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F 312	Continued From page 24 AM Resident #114 stated a therapy staff member had observed him shaving this morning. His hair remained unclean with white flaky particles noted at his hairline. A subsequent observation on 03/25/15 at 9:22 AM revealed his hair was unclean with white flaky particles noted at his hairline. During an interview on 03/27/15 at 12:07 PM Nurse Aide (NA) #14 confirmed she worked on Resident #114's hall on 03/21/14 (Saturday) during the 3:00 PM to 11:00 PM shift. NA #14 stated she was the only NA for the hall until 5:00 PM until another NA came to help her and there was not time for showers. NA #14 further stated it was very busy again on 03/22/15 and she did not have time to shower any residents and had passed this information on to the nurse. An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift. 3. Resident #129 was admitted on 02/19/15 with diagnoses including arthritis, muscle weakness, chronic pain, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) dated 02/26/15 revealed Resident #129 was cognitively intact, required extensive assistance with transfers, and one person assistance with bathing. Review of the facility's shower book revealed Resident #129's showers were scheduled for	F 312		

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F 312	Continued From page 25 every Tuesday and Friday during the 3:00 PM to 11:00 PM shift. The facility was not able to locate any shower documentation for Resident #129 after 03/13/15. During an interview on 03/26/15 at 8:13 AM Resident #129 stated she did not receive her scheduled shower on 03/24/15 and it was important to her to get her two showers a week. Resident #129 further stated she was told there was not enough staff working to give showers on 03/24/15. An interview was conducted with Nurse Aide (NA) #9 on 03/27/15 at 2:59 AM. During the interview NA #9 confirmed she worked Resident #129's hall on 03/24/15 during the 3:00 PM to 11:00 PM shift. NA #9 stated initially there were only 4 NAs for the entire facility and someone came in to help but then left. NA #9 further stated she did not shower Resident #129 on 03/24/15 because there was not enough staff working to provide showers. An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/24/15

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F 323	Continued From page 26	F 323		
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement an intervention to alert staff the resident was attempting to transfer out of bed without assistance for 1 of 3 residents reviewed for accidents (Resident #76). The findings included: Resident #76 was readmitted on 01/11/14 with diagnoses including hemiplegia, contractures of the lower left leg joint, hypotension, and muscle weakness. Review of a care plan dated 04/24/14 revealed Resident #76 had a high risk for falls related to confusion, gait and balance problems, and hemiparesis. Interventions included to anticipate and meet his needs, keep call light in reach and encourage to call for assist, left arm tray for support of extremity in wheelchair, assist bars to aide in bed mobility, and geo mattress with wings to assist with identifying parameters of bed. Review of an annual Minimum Data Set (MDS) dated 05/15/14 revealed Resident #76 had severely impaired cognition and required extensive assistance with bed mobility and transfers. The annual MDS noted Resident #76 had impaired range of motion of his upper and lower extremity on one side of his body and walking did not occur. In addition, no falls were noted since the previous assessment.		F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #76 fall interventions (bed bolsters, personal alarms to bed and chair, and fall mats beside bed) have been implemented. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Director of Nursing/Unit Manager or designee will audit current residents by observational rounds and verification to ensure fall interventions are implemented appropriately as per the care plan. Director of Nursing or designee will re-educate all licensed nurses and CNAs on maintaining environment free of accident hazards, adequate supervision to prevent accidents and what to do when a fall occurs. This was completed by 4/24/2015. Any staff member not completing the re-education will be removed from the schedule until they complete the education.	

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F 323	Continued From page 27 Review of a Care Area Assessment (CAA) Summary for falls dated 05/15/14 revealed Resident #76 was at risk for falls due to confusion, gait and balance problems, and hemiparesis. The CAA Summary noted the attempts would be made to keep staff and routine consistent and he would be care planned for optimal safety. Review of a care plan dated 10/27/14 revealed Resident #76 had an actual fall with no injury related to hypotension. Interventions included to continue the interventions on the at risk care plan, monitor for adverse effects of medications, educate to call for assistance, and pharmacy consult. Review of Resident #76's post fall assessments and fall documentation from 10/2014 through 03/2015 revealed the following: - On 10/26/14 at 8:30 AM Resident #76 had an unwitnessed fall and was found on the floor next to his bed. He told the nurse he was trying to get up to go to the kitchen. No injuries were noted. A hematoma was noted on his forehead and he was sent to the hospital for an evaluation. Personal alarms were added for safety. - On 11/10/14 at 4:44 AM Resident #76 had an unwitnessed fall and was found on the floor next to his bed. The bed bolsters and bed alarm were in place at the time of the fall. Falls mats were implemented on both sides of his bed. - On 03/11/15 at 5:00 AM Resident #76 had an unwitnessed fall from and was found supine of the floor by his bed. Resident #76 reported back and chest pain and x-ray were completed with no fractures or injury noted. Neurological checks were completed. No changes were made to the interventions for falls.	F 323	Measures to be put in place or systemic changes made to ensure practice will not re-occur- The Director of Nursing/Unit Manager or designee will audit 10% resident census to ensure that fall interventions if indicated are implemented □ by observational rounding with verification (Monday □ Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	

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F 323	Continued From page 28 -On 03/13/15 at 5:50 AM the nurse was alerted by the nurse aide that Resident #76 was lying on the floor near his bed. He told the nurse he rolled out of bed and reported a headache. The bed bolsters were in place at the time of the fall. The nurse noted an abrasion to his head and skin tears to his left knee and right elbow. Resident #76 was sent to the hospital for an evaluation and returned to the facility. The nurse also noted a pressure bed alarm was not in place at the time of the fall and she placed one on his bed. Review of a nurse's note dated 03/13/15 revealed Nurse #5 was alerted by the nurse aide that Resident #76 was lying on the floor near his bed. He stated he rolled out of bed and hit his head. Nurse #5 observed an abrasion to his head and skin tears to his left knee and right elbow. Neurological checks were within normal limits. Resident #76 was sent to the hospital for an evaluation and returned to the facility. A CT (computerized tomography) scan performed at the hospital was negative for head injury. Nurse #5 documented she placed a pressure pad alarm on Resident #76's bed. Resident #76 was observed on 03/23/15 at 11:00 AM up and dressed in his wheelchair wearing a splint on his left leg and foot. A seat pad alarm and foot rests were also noted. Subsequent observations of Resident #76 in bed on 03/24/15 at 3:40 PM, 03/25/15 at 10:37 AM and 03/26/15 at 8:00 AM revealed a low bed with bilateral bolsters, mats on the floor on each side of his bed and a pressure bed alarm in use. An interview with Nurse Aide (NA) #4 at 03/26/15 at 1:07 PM revealed Resident #76 had a history of falls and had personal alarms used in his chair	F 323		

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F 323	Continued From page 29 and bed. NA #4 stated his bed was kept in the low position with bilateral bolsters and mats on the floor on each side of his bed. An interview was conducted with the Administrator on 03/26/15 at 1:50 PM. During the interview the Administrator stated Resident #76 should have had a pressure bed alarm in place on 03/13/15 to alert staff he was attempting to transfer out of bed without assistance and prevent further falls or injuries. During an interview on 03/27/15 at 9:12 AM Nurse #5 confirmed she was working on 03/13/15 when Resident #76 had a fall from his bed. Nurse #5 stated she did not work that hall all the time and was not aware if he was supposed to have a bed alarm or not. Nurse #5 recalled a nurse aide (NA) told her Resident #76 was supposed to a pressure bed alarm so she placed one on his bed. The interview further revealed Nurse #5 could not recall which NA told her Resident #76 was supposed to have a bed alarm on 03/13/15.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		4/24/15

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F 328	Continued From page 30	F 328		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility failed to secure 2 compressed oxygen cylinders in a resident's room for 1 of 1 observation of unsecured compressed oxygen cylinders (Resident #269).

The findings included:

Review of the facility policy for Respiratory/Oxygen Equipment effective date of 02/01/15 revealed under Oxygen Cylinder Use was to:
- Maintain proper storage, internal transportation and use of oxygen cylinders. Oxygen cylinders must be kept secure.
a. Do not allow oxygen cylinder to be overturned or sustain a blow that may break off the top.
b. Tanks must be in a cart or stand made for the type of tank being used or stored in a rack.

An observation was made on 03/23/15 at 1:17 PM of 1 portable compressed oxygen cylinder with the gauge reading ½ full lying on the end of Resident #269's bed and 1 portable compressed oxygen cylinder with the gauge reading ½ full leaned against the wall in front of Resident #269's bed side table. Resident #269 was not in the room at the time of the observation but her roommate Resident #145 was lying in her bed.

An interview was conducted on 03/23/15 at 1:23 PM with nurse aide #4 (NA). She stated the portable compressed oxygen cylinders should not have been lying on Resident #269's bed or leaned against her wall. She stated all full or

F328 How corrective action will be accomplished for each resident found to have been affected by the deficient practice The administrator and Director of Nursing removed the compressed oxygen cylinders from Resident #269s room and placed them in the appropriate location on 3/23/15 and all staff were inserviced on compressed oxygen cylinders storage and transfers by 4/24/15.

How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice
The Central Supply Coordinator or designee will round to make sure all compressed oxygen cylinders are secured appropriately following facility policy # 2701 which reads:

1. Maintain proper storage, internal transportation and use of oxygen cylinders. Oxygen cylinders must be kept secure. Do not allow oxygen cylinder to be overturned or sustain a blow that may break off the top.
2. Tanks must be in a cart or stand made for the type of tank being used or stored in a rack.

Director of Nursing or designee will

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F 328	Continued From page 31 empty oxygen cylinders should be secured in a stand or on the back of the resident's wheelchair. An observation and interview was conducted on 03/23/15 at 1:26 PM with the Administrator and the Director of Nursing (DON). They observed, along with the surveyor, the portable compressed oxygen cylinder's in Resident #269's room lying on the bed and leaned against the wall. The Administrator and the DON agreed the oxygen cylinder gauges showed both tanks to be half full. They further stated it was unacceptable for the oxygen cylinders to be unsecured in a resident's room. The Administrator stated the oxygen cylinders should have been secured in the storage room.	F 328	re-educate all staff on maintaining proper storage, internal transportation and use of oxygen cylinders. This was completed by 4/24/2015. Any staff not completing this re-education will be removed from the schedule until they complete it. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- The Central Supply Coordinator or designee will round to make sure all compressed oxygen cylinders are secured appropriately following facility policy # 2701 pages 153-154. These rounds will be documented daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and quarterly x 1. weekly x 2 weeks, bimonthly x 1 month, and monthly x 1. The Director of Nursing/Unit Manager or designee will educate all newly hired employees in orientation on compressed oxygen cylinders storage and transfers. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The Director of Nursing or designee will report the results of these audits in weekly Quality Assurance Risk Meetings X3 months and Quarterly Quality Assurance	

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F 328	Continued From page 32	F 328	Meetings X 1 for further problem resolution.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to administer an as needed antianxiety medication for 1 of 3 sampled residents who requested as needed medications (Resident #114), the facility failed to provide scheduled showers for 3 of 7 residents reviewed for activities of daily living (Residents #104, #114, and #129) and the facility failed to	F 353	F353 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #114, #104, #260 and #154 no longer reside at CROB. The Director of Nursing/Unit Manger or designee have developed new staffing patterns by reallocating 2 FTEs to the 7-3	4/24/15

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serve food at palatable temperatures for 3 of 3 residents (Resident #242, #260, and #154) due to insufficient staffing.

The findings included:

1. Resident #114 was admitted on 02/12/15 for rehabilitation services after a hospitalization with diagnoses including depression.

Review of an admission Minimum Data Set (MDS) dated 02/19/15 revealed Resident #114 was cognitively intact.

Review of physician's orders for March 2015 revealed Resident #114 was ordered Ativan (antianxiety medication) 0.5 mg (milligrams) by mouth every six hours as needed for anxiety.

A review of staffing assignments from 02/01/15 through 03/30/15 revealed 3 days with 2 nurses working the 7:00 AM to 3:00 PM shift, 1 day with 2 nurses working the 3:00 PM to 11:00 PM shift and 5 days with 2 nurses working the 11:00 PM to 7:00 AM shift.

During an interview on 03/26/15 at 9:07 AM Resident #114 stated he had waited two hours for a dose of his as needed Ativan recently but could not recall the exact day. Resident #114 further stated he knew he waited two hours because he had looked at the clock. Resident #114 explained he sometimes felt nervous and his hands would shake and the Ativan helped with these symptoms. Resident #114 stated he was told the nurses were in report as the reason for the delay.

An interview was conducted with the

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shift to assure the facility has adequate nursing staff to provide nursing and related services to attain or maintain the highest physical, mental, and psychosocial well-being of each resident.

How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice
The Director of Nursing/Unit Manger or designee will audit staffing assignment sheets daily to assure adequate staffing to meet resident needs and to adjust assignments according to resident needs daily (Monday-Friday) X 2 weeks, weekly X 2 weeks, bimonthly X 1 month, and Quarterly X 1.

The Daily Nursing Staffing Summary which lists licensed nurses and CNAs according to the resident census will be reviewed daily for each shift by the DON or designee to ensure sufficient staff will be provided based on current census and resident needs.

The Director of Nursing/Unit Manager or designee will inservice nursing staff to address the importance and expectations of meeting the resident care needs bathing/showers, serving warm food, and timely administration of as needed medications. All staff are required to receive this inservice and cannot work until they do.

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Administrator on 03/30/15 at 10:22 AM. During the interview the Administrator stated residents should not have to wait two hours for the nurse to administer medications after they were requested. The interview further revealed the Administrator was not aware of any problems or concerns regarding medication pass.

A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 7:00 AM to 3:00 PM shift, 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift and 3 nurses and 5 NAs on the 11:00 PM to 7:00 AM shift but they had been short staffed for the past couple of months.

2. Resident #104 was admitted on 03/01/15 for rehabilitation services after a hospitalization with diagnoses including muscle weakness.

Review of an admission Minimum Data Set (MDS) dated 03/08/15 revealed Resident #104 was cognitively intact and required extensive assistance with transfers and one person physical assistance with bathing.

A review of staffing assignments from 02/01/15 through 03/30/15 revealed 9 days out of that time period only 4-5 NAs worked the 11:00 PM to 7:00 AM shift.
Review of the facility's shower book revealed

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Measures to be put in place or systemic changes made to ensure practice will not Re-occur-

The Director of Nursing/Unit Manager or designee will interview 10% of current census of residents to identify any resident care or staffing concerns. These interviews will be conducted - daily (Monday Friday) x 2 weeks, weekly x 2 weeks, bimonthly x 1 month, and monthly x 1.

The Director of Nursing/Unit Manager or designee will in-service new nursing staff in orientation to address the importance and expectations of meeting the resident care needs bathing/showers, serving warm food, and timely administration of as needed medications.

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-

The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.

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F 353	Continued From page 35 Resident #104's showers were scheduled for every Tuesday and Friday during the 3:00 PM to 11:00 PM shift. Review of available shower documentation for Resident #104 revealed showers were initialed as completed on 03/10/15 and the therapy department staff assisted her with a shower on 03/17/15 (Tuesday). During an interview on 03/25/15 at 9:10 AM Resident #104 stated her last shower had been on Monday or Tuesday of the previous week and she would like a shower more frequently. An interview was conducted on 03/25/15 at 9:19 AM with NA #4. She stated they have been working with 1 to 2 NAs on a hall for the past couple of months. She stated she cannot get all of the showers done during her shift and reports it to the nurse and the next shift NAs. An interview was conducted on 03/25/15 at 12:44 AM with NA #15. She reported the facility is short staffed and sometimes there are only 3 to 4 NAs in the building. She stated it was impossible to get showers done on days with only 3 to 4 NAs working. An interview was conducted with Nurse Aide (NA) #12 on 03/27/15 at 3:17 PM. NA #12 confirmed she worked on Resident #104's hall on 03/20/14 (Friday) during the 3:00 PM to 11:00 PM shift. NA #12 did not recall if any showers were given that evening or if Resident #104 received her scheduled shower on 03/20/15 because she typically stayed on the hall and her coworker completed the showers. The interview further revealed if there were not enough NAs scheduled then scheduled showers were not given.	F 353		

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An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift.

A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift but they had been short staffed for the past couple of months.

During an interview on 03/30/15 at 12:05 PM NA #13 confirmed she worked on Resident #104's hall on 03/20/14 (Friday) during the 3:00 PM to 11:00 PM shift. NA #13 did not recall assisting Resident #104 with a shower that evening. NA #13 stated there were only 6 NAs for the facility that evening and they would not have been able to complete all the scheduled showers but would have offered residents a bed bath.

3. Resident #114 was admitted on 02/12/15 for rehabilitation services after a hospitalization with diagnoses including chronic obstructive pulmonary disease and coronary artery disease.

Review of an admission Minimum Data Set (MDS) dated 02/19/15 revealed Resident #114 was cognitively intact and required one person assistance with bathing.

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A review of staffing assignments from 02/01/15 through 03/30/15 revealed 9 days out of that time period only 4-5 NAs worked the 11:00 PM to 7:00 AM shift.
Review of the facility's shower book revealed Resident #114's showers were scheduled for every Wednesday and Saturday during the 3:00 PM to 11:00 PM shift. Review of available shower documentation for Resident #114 revealed showers were initialed as completed on 03/04/15, 03/07/15, and 03/18/15.

During an interview on 03/23/15 at 1:20 PM Resident #114 stated he did not choose how many showers he had a week and was last showered on Wednesday (03/18/15). Resident #114 further stated he did not receive his scheduled shower on Saturday (03/21/15) and was told there were not enough staff working to give showers.

Observations of Resident #114 on 03/23/15 at 1:20 PM revealed his hair was unclean with white flaky particles noted at his hairline and several days ' growth of facial hair. On 03/24/15 at 11:54 AM Resident #114 stated a therapy staff member had observed him shaving this morning. His hair remained unclean with white flaky particles noted at his hairline. A subsequent observation on 03/25/15 at 9:22 AM revealed his hair was unclean with white flaky particles noted at his hairline.

An interview was conducted on 03/25/15 at 9:19 AM with NA #4. She stated they have been working with 1 to 2 NAs on a hall for the past couple of months. She stated she cannot get all of the showers done during her shift and reports it to the nurse and the next shift NAs.

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An interview was conducted on 03/25/15 at 12:44 AM with NA #15. She reported the facility is short staffed and sometimes there are only 3 to 4 NAs in the building. She stated it was impossible to get showers done on days with only 3 to 4 NAs working.

During an interview on 03/27/15 at 12:07 PM Nurse Aide (NA) #14 confirmed she worked on Resident #114's hall on 03/21/14 (Saturday) during the 3:00 PM to 11:00 PM shift. NA #14 stated she was the only NA for the hall until 5:00 PM until another NA came to help her and there was not time for showers. NA #14 further stated it was very busy again on 03/22/15 and she did not have time to shower any residents and had passed this information on to the nurse.

An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift.

A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift but they had been short staffed for the past couple of months.

4. Resident #129 was admitted on 02/19/15 with

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diagnoses including arthritis, muscle weakness, chronic pain, and chronic obstructive pulmonary disease.

Review of the admission Minimum Data Set (MDS) dated 02/26/15 revealed Resident #129 was cognitively intact, required extensive assistance with transfers, and one person assistance with bathing.

A review of staffing assignments from 02/01/15 through 03/30/15 revealed 9 days out of that time period only 4-5 NAs worked the 11:00 PM to 7:00 AM shift.
Review of the facility's shower book revealed Resident #129's showers were scheduled for every Tuesday and Friday during the 3:00 PM to 11:00 PM shift. The facility was not able to locate any shower documentation for Resident #129 after 03/13/15.

An interview was conducted on 03/25/15 at 9:19 AM with NA #4. She stated they have been working with 1 to 2 NAs on a hall for the past couple of months. She stated she cannot get all of the showers done during her shift and reports it to the nurse and the next shift NAs.

An interview was conducted on 03/25/15 at 12:44 AM with NA #15. She reported the facility is short staffed and sometimes there are only 3 to 4 NAs in the building. She stated it was impossible to get showers done on days with only 3 to 4 NAs working.

During an interview on 03/26/15 at 8:13 AM Resident #129 stated she did not receive her scheduled shower on 03/24/15 and it was important to her to get her two showers a week.

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Resident #129 further stated she was told there was not enough staff working to give showers on 03/24/15.

An interview was conducted with Nurse Aide (NA) #9 on 03/27/15 at 2:59 AM. During the interview NA #9 confirmed she worked Resident #129's hall on 03/24/15 during the 3:00 PM to 11:00 PM shift. NA #9 stated initially there were only 4 NAs for the entire facility and someone came in to help but then left. NA #9 further stated she did not shower Resident #129 on 03/24/15 because there was not enough staff working to provide showers.

An interview with the Administrator on 03/30/15 at 10:24 AM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during their shift.

A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift but they had been short staffed for the past couple of months.

5. Resident #242 was admitted to the facility on 01/15/15. Resident #242's most recent Minimum Date Set assessment dated 02/18/15 indicated Resident #242 was cognitively intact, alert and orientated with a recorded Brief Interview for

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F 353	Continued From page 41 Mental Status score of 15. A review of staffing assignments from 02/01/15 through 03/30/15 revealed 7 days out of that time period there were 4-5 nurse aides (NAs) that worked the 7:00 AM to 3:00 PM shift, 9 days out of that time period 4-5 NAs that worked the 3:00 PM to 11:00 PM shift and 10 days out of that time period 3 NAs that worked the 11:00 PM to 7:00 AM shift. During the same time period there were 3 days with 2 nurses working the 7:00 AM to 3:00 PM shift, 1 day with 1 nurse working the 3:00 PM to 11:00 PM shift and 5 days with 1-2 nurses working the 11:00 PM to 7:00 AM shift. An interview was conducted with Resident #242 on 03/24/15 at 3:40 PM. Resident #242 reported the breakfast, lunch and dinner meals served by the facility are frequently cold. Resident #242 added that the food is sometimes warm but never hot. A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served. DM provided tray service audits which recorded food temperatures from test trays and resident	F 353		

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complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long.

During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays.

A staff interview was conducted 03/27/15 at 9:45 AM with NA #7. She reported that due to low staffing levels it is often difficult for the staff to serve meal trays before they get cold.

A staff interview was conducted with NA #6 03/27/15 at 10:34 AM. She verbalized that it's hard to get the food trays served hot when there are only 6 NAs working in the facility and added that any need to respond to call bells or emergencies makes it impossible for the NAs to serve the residents food while it's hot. NA #6

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reported that staff other than NAs seldom assist with passing meal trays to residents.
A staff interview was conducted with Administrator and DON on 3/27/15 at 3:45 PM. They verbalized their expectation was that food served to residents be at a palatable eating temperature. They confirmed that the DM had discussed residents being served cold food with them and that the DM had implemented a new system of passing trays in an effort to prevent residents from being served cold food.

A follow up interview was conducted on 03/30/11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 7:00 AM to 3:00 PM shift, 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift and 3 nurses and 5 NAs on the 11:00 PM to 7:00 AM shift but they had been short staffed for the past couple of months. The Administrator further stated residents should not be receiving cold food due to staffing.

6. Resident #260 was admitted to the facility for rehabilitation services on 03/06/15.

An interview was conducted with Resident #260 on 03/23/15. Resident #260 was alert and oriented with no memory problems noted. During the interview Resident # 260 stated he ate in his room and his food was cold at every meal. Resident #260 stated he had complained about

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the cold food to staff but it did not do any good.

A follow up interview was conducted with Resident #260 while he was eating his breakfast his breakfast on 03/26/15 at 8:48 AM. Resident #260 stated his breakfast was barely warm this morning and commented that most all of his meals were served barely warm.

A review of staffing assignments from 02/01/15 through 03/30/15 revealed 7 days out of that time period there were 4-5 nurse aides (NAs) that worked the 7:00 AM to 3:00 PM shift, 9 days out of that time period 4-5 NAs that worked the 3:00 PM to 11:00 PM shift and 10 days out of that time period 3 NAs that worked the 11:00 PM to 7:00 AM shift. During the same time period there were 3 days with 2 nurses working the 7:00 AM to 3:00 PM shift, 1 day with 1 nurse working the 3:00 PM to 11:00 PM shift and 5 days with 1-2 nurses working the 11:00 PM to 7:00 AM shift.

A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served. DM provided tray service audits which recorded food temperatures from test trays and resident

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F 353	Continued From page 45 complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long. During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays. During an interview on 03/27/15 at 12:07 AM Nurse Aide (NA) #14 stated the NAs were responsible for passing the food trays and there were usually 2 NAs for the hall when she worked. NA #14 explained passing food trays was often delayed due to resident care and answering call bells. NA #14 noted she was aware of cold food complaints from residents and she would warm up resident's food when they asked her to. On 03/27/15 at 10:34 AM NA #6 stated during interview that it was difficult to get the food trays served hot when there was only 6 NAs in the	F 353		

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building and it was impossible with less than 6. She further indicated that answering call bells caused the delay in passing the trays out on the hall.

An interview with the Administrator on 03/27/15 at 3:45 PM revealed she expected food to be served to the residents at palatable temperatures. The Administrator stated the Dietary Manager had discussed recent cold food concerns and had implemented a new system of food cart delivery to the halls to prevent residents from being served cold food.

A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 7:00 AM to 3:00 PM shift, 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift and 3 nurses and 5 NAs on the 11:00 PM to 7:00 AM shift but they had been short staffed for the past couple of months. The Administrator further stated residents should not be receiving cold food due to staffing.

7. Resident #154 was admitted to the facility on 11/10/14. The most recent Minimum Data Set a quarterly dated 02/25/15 coded her as scoring a 15 out of 15 on the Brief Interview for Mental Status indicating she was cognitively intact.

A review of staffing assignments from 02/01/15 through 03/30/15 revealed 7 days out of that time

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CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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period there were 4-5 nurse aides (NAs) that worked the 7:00 AM to 3:00 PM shift, 9 days out of that time period 4-5 NAs that worked the 3:00 PM to 11:00 PM shift and 10 days out of that time period 3 NAs that worked the 11:00 PM to 7:00 AM shift. During the same time period there were 3 days with 2 nurses working the 7:00 AM to 3:00 PM shift, 1 day with 1 nurse working the 3:00 PM to 11:00 PM shift and 5 days with 1-2 nurses working the 11:00 PM to 7:00 AM shift.

On 03/24/15 at 9:46 AM, Resident #154 stated that the food could be hotter and the staff will heat in the microwave if you ask them. She further stated she has gotten used to eating cold food.

On 03/25/15 at 9:25 AM, Resident #154 had just finished breakfast. She stated that she had French toast and bacon. She further stated that the breakfast meal was too cold and that breakfast was cold every day. Resident #154 stated that she had complained before and when she has complained about the cold food, staff reheated it. She continued stating that she used to be on hall 200 and there she described the breakfast as always cold and the other meals were always lukewarm.

A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and

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had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served. DM provided tray service audits which recorded food temperatures from test trays and resident complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long.

During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays.

On 03/27/15 at 9:45 AM, Nurse Aide (NA) #7 stated that staffing levels resulted in difficulty for staff to be able to pass the food trays to the residents before the food got cold. She further verbalized that only 1 NA was assigned to pass

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F 353	Continued From page 49 32 breakfast trays this date. On 03/27/15 at 10:34 AM, Nurse Aide (NA) #6 stated during interview that it was difficult to get the food trays served hot when there was only 6 nurse aides in the building and it was impossible with less than 6. She further indicated that answering call bells caused the delay in passing the trays out on the hall. An interview with the Administrator on 03/27/15 at 3:45 PM revealed she expected food to be served to the residents at palatable temperatures. The Administrator stated the Dietary Manager had discussed recent cold food concerns and had implemented a new system of food cart delivery to the halls to prevent residents from being served cold food. A follow up interview was conducted on 03/30/15 at 11:04 AM with the Administrator and the DON. The DON stated if there were call outs for the next shift it was the nurse on duty responsibility to find coverage for that shift or stay over until coverage was found. She stated she reviewed the staffing sheets daily and made adjustments as needed. The Administrator stated the facility policy was to have 5 nurses and 8 NAs on the 7:00 AM to 3:00 PM shift, 5 nurses and 8 NAs on the 3:00 PM to 11:00 PM shift and 3 nurses and 5 NAs on the 11:00 PM to 7:00 AM shift but they had been short staffed for the past couple of months. The Administrator further stated residents should not be receiving cold food due to staffing.	F 353		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	F 360		4/24/15

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F 360	Continued From page 50 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide a bag lunch for 1 of 1 resident receiving dialysis three times a week (Resident #269). The findings included: Resident #269 was admitted to the facility on 03/04/15 with diagnoses of renal failure and diabetes. The admission Minimum Data Set (MDS) dated 03/04/15 revealed Resident #269 was cognitively intact. The MDS further stated Resident #269 received dialysis. The care plan dated 03/09/15 revealed Resident #269 had the potential for a nutritional problem related to renal and restricted concentrated sugars diet restrictions and diuretic use. Interventions included explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. Provide, serve diet as ordered. Monitor intake and record every meal. Weekly weights. An observation was made on 03/26/15 at 11:24 AM of Resident #269 signing out with the Administrator at the 100 hall nurse's desk to go to dialysis. Resident #269 did not have a bag lunch	F 360	F360 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident # 269 has and will continue to have a bagged lunch provided by the facility three times a week while receiving dialysis. Dietary staff is hand delivering bagged lunch to patient prior to her dialysis treatment. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Dietary Manager &/or Register Dietitian or designee will audit all current residents receiving dialysis to ensure bag lunches are provided to residents receiving dialysis. The Dietary Manager and/or designee will educate facility staff regarding the importance or providing each resident with a nourishing, well balanced diet to meet the needs of each resident. This	

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F 360	Continued From page 51 to take to dialysis. An interview was conducted on 03/25/15 at 9:30 AM with Resident #269. She stated she goes to dialysis 3 days a week, Tuesday, Thursday and Saturday from 12:00 PM to 4:00 PM and a family member takes her. Resident #269 stated the facility had never offered to bring her a tray before she went to dialysis or send a bag lunch with her. She stated she was not aware she could take a bag lunch from the facility with her to dialysis. She stated she and her family member ate at a local restaurant on the way to dialysis but it would be nice to have a bag lunch because they didn't always have money to eat. An interview was conducted on 03/26/15 at 11:16 AM with nurse aide (NA) #4. She stated she did not know if Resident #269 took a bag lunch to dialysis. NA #4 stated Resident #269 went to dialysis with her family member and he got her ready and to the car without help from the staff. An interview was conducted on 03/26/15 at 11:25 AM with Resident #269. She stated she had not received a lunch tray and no one had offered to send a bag lunch with her to dialysis. An interview was conducted on 03/26/15 at 11:26 AM with the Administrator. She stated the transporter/driver that took the resident to dialysis should have gone to the kitchen to get a bag lunch for Resident #269. The Administrator stated she was unaware that Resident #269's family was taking her to dialysis and she called the kitchen and had them bring Resident #269 a bag lunch to take with her. An interview was conducted on 03/26/15 at 1:08	F 360	education will be completed by 4/24/15 and staff not receiving this education will be removed from the schedule until they receive the education. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- All new admissions and re-admissions will be reviewed for offsite dialysis treatments to ensure bag lunches are being provided to residents that receive dialysis. The Dietary Manager &/or Register Dietitian or designee will review new admission and re-admission alerts to ensure that all dialysis residents are receiving a bag lunch when scheduled for dialysis. These audits will be performed daily (Mon-Fri) x 2weeks and bi-monthly x1 month and monthly x 2months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Dietary Manager &/or Register Dietitian or designee will report the results of these audits in Weekly Quality Assurance Risk Meetings x3 months and quarterly Quality Assurance Meetings x 1 month for further problem resolution.	

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F 360	Continued From page 52 PM with the Dietary Manager, (DM). She stated resident ' s that receive dialysis were sent with a bag lunch to dialysis and received their lunch tray when they returned from dialysis. She stated the kitchen made up bag lunches daily and the transporter/driver that took the resident to dialysis came to the kitchen to pick up the bag lunch for the resident. The DM stated she was unaware Resident #269's family member took her to dialysis and she wasn't receiving a bag lunch to take with her. She further stated the kitchen staff would start taking Resident #269's bag lunch to her before she left for dialysis. A follow up interview was conducted with the Administrator on 03/27/15 at 10:24 AM. She stated the bag lunch process should have been discussed with Resident #269 upon admission and a bag lunch should have been sent to dialysis with Resident #269 without her having to ask for one.	F 360		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews with staff and residents the facility failed to serve food at palatable temperatures for 3 of 3 residents (Resident #242, #260, and #154).	F 364	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and	4/24/15

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F 364	Continued From page 53 Findings included: 1. Resident #242 was admitted to the facility on 01/15/15. Resident #242's most recent Minimum Date Set assessment dated 02/18/15 indicated Resident #242 was cognitively intact, alert and orientated with a recorded Brief Interview for Mental Status score of 15. An interview was conducted with Resident #242 on 03/24/15 at 3:40 PM. Resident #242 reported the breakfast, lunch and dinner meals served by the facility are frequently cold. Resident #242 added that the food is sometimes warm but never hot. A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served. DM provided tray service audits which recorded food temperatures from test trays and resident complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at	F 364	federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F364 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Resident # 154 & 260 no longer reside at Carolina Rehab Center of Burke. Resident #242 has been interviewed and documentation reflecting that the facility food temperatures have improved. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The Dietary Manager & Administrator have educated dietary staff on the subject of heat on demand system, plate warming system, food temperatures, new tray meal schedule and dining room program. The Dietary Manager &/or Register Dietitian or designee will perform tray service audits to validate food temperatures for patients receiving meals in their rooms. These are will be performed three times a week for two weeks; weekly for two weeks;	

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F 364	Continued From page 54 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long. During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays. A staff interview was conducted 03/27/15 at 9:45 AM with NA #7. She reported that due to low staffing levels it is often difficult for the staff to serve meal trays before they get cold. A staff interview was conducted with NA #6 03/27/15 at 10:34 AM. She verbalized that it's hard to get the food trays served hot when there are only 6 NAs working in the facility and added that any need to respond to call bells or emergencies makes it impossible for the NAs to serve the residents food while it's hot. NA #6 reported that staff other than NAs seldom assist with passing meal trays to residents. A staff interview was conducted with Administrator and DON on 3/27/15 at 3:45 PM. They verbalized their expectation was that food	F 364	bi-monthly x one month; and monthly x one month. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- All patients will be encouraged to attend dining room program. The Dietary Manager &/or Register Dietitian or designee will perform tray service audits to validate food temperatures for patients receiving meals in their rooms. These are will be performed three times a week for two weeks; weekly for two weeks; bi-monthly x one month; and monthly x one month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The Dietary Manager &/or Register Dietitian or designee will perform tray service audits to validate food temperatures for patients receiving meals in their rooms. These are will be performed three times a week for two weeks; weekly for two weeks; bi-monthly x one month; and monthly x one month. The results of these audits will be reviewed in Weekly Quality Assurance Risk Meetings x3 months and quarterly Quality Assurance Meetings x 1 month for further problem resolution.	

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F 364	Continued From page 55 served to residents be at a palatable eating temperature. They confirmed that the DM had discussed residents being served cold food with them and that the DM had implemented a new system of passing trays in an effort to prevent residents from being served cold food. 2. Resident #260 was admitted to the facility for rehabilitation services on 03/06/15. An interview was conducted with Resident #260 on 03/23/15. Resident #260 was alert and oriented with no memory problems noted. During the interview Resident # 260 stated he ate in his room and his food was cold at every meal. Resident #260 stated he had complained about the cold food to staff but it did not do any good. A follow up interview was conducted with Resident #260 while he was eating his breakfast his breakfast on 03/26/15 at 8:48 AM. Resident #260 stated his breakfast was barely warm this morning and commented that most all of his meals were served barely warm. A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served.	F 364		

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F 364	Continued From page 56 DM provided tray service audits which recorded food temperatures from test trays and resident complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be good if it didn't sit on the hallway so long. During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays. During an interview on 03/27/15 at 12:07 AM Nurse Aide (NA) #14 stated the NAs were responsible for passing the food trays and there were usually 2 NAs for the hall when she worked. NA #14 explained passing food trays was often delayed due to resident care and answering call bells. NA #14 noted she was aware of cold food complaints from residents and she would warm up resident's food when they asked her to.	F 364		

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On 03/27/15 at 10:34 AM NA #6 stated during interview that it was difficult to get the food trays served hot when there was only 6 NAs in the building and it was impossible with less than 6. She further indicated that answering call bells caused the delay in passing the trays out on the hall.

An interview with the Administrator on 03/27/15 at 3:45 PM revealed she expected food to be served to the residents at palatable temperatures. The Administrator stated the Dietary Manager had discussed recent cold food concerns and had implemented a new system of food cart delivery to the halls to prevent residents from being served cold food.
3. Resident #154 was admitted to the facility on 11/10/14.

The most recent Minimum Data Set a quarterly dated 02/25/15 coded her as scoring a 15 out of 15 on the Brief Interview for Mental Status indicating she was cognitively intact.

On 03/24/15 at 9:46 AM, Resident #154 stated that the food could be hotter and the staff will heat in the microwave if you ask them. She further stated she has gotten used to eating cold food.

On 03/25/15 at 9:25 AM, Resident #154 had just finished breakfast. She stated that she had french toast and bacon. She further stated that the breakfast meal was too cold and that breakfast was cold every day. Resident #154 stated that she had complained before and when she has complained about the cold food, staff reheated it. She continued stating that she used to be on hall 200 and there she described the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING ______ B. WING ______	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 58 breakfast as always cold and the other meals were always lukewarm. A staff interview was conducted with the Dietary Manager (DM) 03/25/15 at 12:34 PM. DM reported that residents had complained to her concerning cold food. DM verbalized that she responded to resident complaints by taking food temperatures from test trays at the time food is being served to residents and confirmed food is being served cold. DM also verbalized that she had discussed the cold food complaints with the Administrator and Director of Nursing (DON) and had implemented a new system of passing trays and cold food complaints continued. The DM reported that the reason food is being served to residents cold is that the trays sit on the hallways in the tray carts too long prior to being served. DM provided tray service audits which recorded food temperatures from test trays and resident complaints related to cold food. The DM's tray service audits recorded resident complaints of food sometimes cold on 01/12/15 with the notation of 1 nurse aide (NA) passing trays and the other NA answering resident's call lights; trays arrived on hall 5:21 PM with last tray served at 6:15 PM. The DM log dated 02/05/15 indicated the DM spoke with NAs on 200 hall concerning resident complaints of cold food and conducted a test tray evaluation which revealed food was being served cold and noted that there were 20 trays to serve and only one NA to pass trays. The DM tray service audit dated 03/02/15 noted that residents complained food was being served cold with trays arriving on hall at 1:00 PM with the last tray served at 1:40 PM. Tray service audit dated 03/03/15 recorded with resident complaints of food being served cold along with a comment from a resident who verbalized the food would be	F 364		

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F 364	Continued From page 59 good if it didn't sit on the hallway so long. During an observation of meal trays being passed 03/25/15 at 1:20 PM the DM indicated that the NAs were primarily responsible to pass meal trays and other staff members seldom assist the NAs to pass trays. On 03/27/15 at 9:45 AM, Nurse Aide (NA) #7 stated that staffing levels resulted in difficulty for staff to be able to pass the food trays to the residents before the food got cold. She further verbalized that only 1 NA was assigned to pass 32 breakfast trays this date. On 03/27/15 at 10:34 AM, Nurse Aide (NA) #6 stated during interview that it was difficult to get the food trays served hot when there was only 6 nurse aides in the building and it was impossible with less than 6. She further indicated that answering call bells caused the delay in passing the trays out on the hall. An interview with the Administrator on 03/27/15 at 3:45 PM revealed she expected food to be served to the residents at palatable temperatures. The Administrator stated the Dietary Manager had discussed recent cold food concerns and had implemented a new system of food cart delivery to the halls to prevent residents from being served cold food.	F 364		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345526	MULTIPLE CONSTRUCTION A. BUILDING: ________ B. WING ________	DATE SURVEY COMPLETE: 3/30/2015
NAME OF PROVIDER OR SUPPLIER **CAROLINA REHAB CENTER OF BURKE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3647 MILLER BRIDGE ROAD CONNELLY SPG, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review and resident and staff interviews the facility failed to notify a resident that his personal funds account exceeded the $1,800.00 Medicaid limit for three months for 1 of 1 sampled resident (Resident #1) and provide cognitively intact residents with a quarterly personal funds account statement for 2 of 2 sampled residents reviewed for personal funds (Resident #1 and #72).

The findings included:

1. Resident #1 was admitted on 07/22/14 for rehabilitation services with diagnoses including muscle weakness and acute on chronic respiratory failure. Review of a quarterly Minimum Data Set (MDS) dated

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01/21/15 revealed Resident #1 was cognitively intact.

During an interview on 03/23/15 at 12:25 PM Resident #1 stated the facility did not let him know how much money he had in his personal funds account and did not provide him with a quarterly personal funds statement.

An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated Resident #1 was admitted with Medicare and was assisted with filing for Medicare. The interview further revealed his Medicaid benefits went into effect on 11/05/14.

Review of Resident #1's quarterly personal funds account statement dated 12/31/14 revealed a closing balance of $2,893.05.

An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. During the interview the Regional Business Office Consultant confirmed Resident #1's Medicaid benefits went into effect on 11/05/14. He further stated residents' personal funds accounts were audited monthly and if they had a balance approaching $1,500.00 dollars the resident or responsible party were contacted. At the conclusion of the interview the Regional Business Office Consultant stated he would review Resident #1's personal funds account transactions from November of 2014 through March of 2015 and discuss his findings later in the day.

An interview with the Business Office Manager (BMO) on 03/27/15 at 10:12 AM revealed she had been in this position for two months and could not recall what her trainer had told her about any requirements on account balance for a resident on Medicaid. The BMO further stated her trainer and the Regional Business Office Consultant and were currently responsible for auditing resident account balances.

During a follow up interview on 03/27/15 at 12:18 PM the Regional Business Office Consultant stated Resident #1's personal funds account had a current balance $2,867.58 dollars as of 03/19/15. The interview further revealed Resident #1's personal funds account balance was $2,800.00 dollars or over in December of 2014, January 2015, and February 2015. The Regional Business Office Consultant further stated the facility's previous BMO would have reviewed Resident #1's November and December of 2014 personal funds accounts statements and Regional Account Specialist would have reviewed the January and February of 2015 monthly statements. The Regional Business Office Consultant stated the overage in Resident #1's account should have been noted during the monthly audits beginning on 12/15/14. The Regional Business Office Consultant confirmed no action had been taken since 12/15/14 to make sure Resident #1 did not lose his Medicaid funding.

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A follow up interview was conducted with Resident #1 on 03/27/15 at 2:38 PM. Resident #1 stated it concerned him that he could have lost his money or Medicaid funding due to an error in the business office.

2. Resident #1 was admitted on 07/22/14 for rehabilitation services with diagnoses including muscle weakness and acute on chronic respiratory failure. Review of a quarterly Minimum Data Set (MDS) dated 01/21/15 revealed Resident #1 was cognitively intact.

During an interview on 03/23/15 at 12:25 PM Resident #1 stated the facility did not let him know how much money he had in his personal funds account and did not provide him with a quarterly personal funds statement.

An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated the facility ' s corporate office was responsible for sending out the quarterly personal funds statements to the residents or their responsible party. Resident #1's quarterly personal funds account statement dated 12/31/14 was reviewed during the interview and revealed he was listed as his own responsible party. The interview further revealed the address on his statement was a former facility.

An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. The Regional Business Office Consultant stated if the resident was their own responsible party they should receive a copy of their quarterly personal funds account statement. The Regional Business Office Consultant reviewed Resident #1's quarterly personal fund statement account dated 12/31/14 during the interview and confirmed the quarterly personal funds statement should have gone straight to him because he was his own responsible party.

An interview with the Admissions Director on 03/27/15 at 10:30 AM revealed Resident #1 signed his admission agreement as his own responsible party. The interview further revealed the Admissions Director put the address in the computer for correspondence from the facility but was not involved with the resident funds account.

During an interview on 03/30/15 at 10:35 AM the Administrator stated cognitively intact residents should receive a copy of their quarterly personal funds account statement.

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3. Resident #72 was admitted on 06/08/11 with diagnoses including chronic obstructive pulmonary disease and heart failure. Review of a quarterly Minimum Data Set (MDS) dated 02/18/15 revealed Resident #72 was cognitively intact.

During an interview on 03/23/15 at 3:15 PM Resident #72 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement.

An interview was conducted with the facility's Accounts Payable Representative on 03/27/15 at 9:53 AM. The Accounts Payable Representative stated the facility's corporate office was responsible for sending out the quarterly personal funds account statements to the residents or their responsible party. Resident #72's quarterly personal funds account statement dated 12/31/14 was reviewed during the interview and revealed she was listed as her own responsible party. The Accounts Payable Representative thought the address on the statement was for a family member.

An interview was conducted with the Regional Business Office Consultant by phone on 03/27/15 at 10:01 AM. The Regional Business Office Consultant stated if the resident was their own responsible party they should receive a copy of their quarterly personal funds account statement. The Regional Business Office Consultant reviewed Resident #72's quarterly personal funds account statement dated 12/31/14 during the interview and confirmed she should receive a copy of her quarterly personal funds statement because she was her own responsible party. The Regional Business Office Consultant further stated Resident #72's quarterly personal funds statement was probably going to her family.

An interview with the Admissions Director on 03/27/15 at 10:30 AM revealed Resident #72 signed her admission agreement as her own responsible party. The interview further revealed the Admissions Director put the address in the computer for correspondence from the facility but was not involved with the resident funds account.

During an interview on 03/30/15 at 10:35 AM the Administrator stated cognitively intact residents should receive a copy of their quarterly personal funds account statement.

F 514

483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

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The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to document new skin tears and treatment in the medical record of 1 of 3 residents sampled for skin integrity issues. (Resident #261).

The findings included:

Resident #261 was admitted to the facility on 03/21/15. His diagnoses included a fall at home, seizure activity, hypertension, diabetes, and status post below knee amputation.

The undated center admission alert form (information obtained by the admission nurse from hospital personnel) noted fragile skin and bruising and a skin tear to left arm.

The initial nursing assessment dated 03/21/15 identified the old surgical scar from his above knee amputation. No other skin issues were identified on the assessment nor on the initial nursing note dated 03/21/15 at 2:58 PM.

On 03/23/15 at 11:18 AM and at 3:27 PM, Resident #261 was observed with a bandage on his left forearm. In addition his skin was observed to be thin and a large scab across his left forearm.

The physician's history and physical dated 03/23/15 noted multiple excoriations and ecchymosis, but no other details about the resident's skin.

On 03/25/15 at 9:17 AM Resident #261 was observed being set up for breakfast. He had a large gauze wrapping around his right hand covering the top of his hand up to his wrist. The surveyor also noted a bandage on his right outer shin close to his knee and blood dripping from an area below the dressing.

Review of the medical record including nursing notes and treatment records revealed nothing related to any treatments or dressings for Resident #261.

On 03/25/15 at 9:21 AM Nurse #2 who was working on the hall stated he normally did not work this hall and the area was there when he arrived. He stated he was told the area on his hand was an old area that just reopened. On 03/25/15 at 10:28 AM, Resident #261 was observed in therapy with a bandage wrapped up his right leg/shin area and a bandage wrapped around his right hand. His hand remained bandaged when observed on 03/26/15 at 6:17 AM.

Interview with the nurse aide #5 on 03/26/15 at 10:08 AM revealed Resident #261 was admitted late on her

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shift and that he came with multiple skin tears. She stated it was her understanding that his hand bandage was a bruise that he had on admission that reopened.

On 03/26/15 at 1:00 PM Nurse #3 stated this was only the second day she had worked with Resident #261. She stated she was informed that he hit his hand propelling his wheelchair. She stated that was what she learned when 3rd shift reported off. Nurse #3 reviewed the medical record and confirmed there were no skin assessments or documentation that Resident #261 had any skin tears or skin integrity issues assessed on admission. She further stated that she would have documented the scattered skin tears but would not have measured or staged anything that was not opened.

On 03/26/15 at 2:17 PM the Director of Nursing (DON) and Administrator were interviewed. They stated that the initial nursing assessment included a wound assessment. Both confirmed that there should be some documentation of the bruises and skin tears observed on a resident upon admission. The DON stated staff were expected to complete a wound assessment and incident report for any new skin tear. If there was a treatment implemented that should be documented on the treatment record.

The first notation of any skin issues related to Resident #261's hand was a incident note in the progress notes dated 03/26/15 at 5:01 PM that stated on 03/23/15 therapy brought the resident to the nurse and stated he scratched his hand and it was bleeding. The nurse was noted to clean the area with normal saline and cover it with a Band-Aid.

On 03/27/15 at 9:33 AM, Resident #261 had no dressing or wrapping on his right hand. there was a large blood red bruise noted to his outer hand.